Revised: October 2024

LIFEWAYS SLIDING FEE APPLICATION

Patient Name: _____Social Security#: *(optional)*_____

Address: _____

City: _____ State: _____ Zip_____ Health Insurance Plan: *(optional)*_____

Home Phone:_____ Cell Phone:_____Employer:_____

Number of household members _____ (list names below)

Name	Date of Birth		Name	Date of Birth	
Self			Dependent		
Spouse			Dependent		
Dependent			Dependent		

Monthly Household: (Income: Prior year tax return, two most recent pay stubs, or pay stub showing YTD)

Source of Monthly Income	Self	Spouse	Dependent Children Under age 18	Total
Gross wages, salaries, tips, ect. (Monthly)				
Alimony, child support. (Monthly)				
Military family allotments, (Monthly)				
social security income and annuity.				
Income from business, pension, (Monthly)				
self-employment.				
Rental, interest, dividend, (Monthly) public income and other income.				
			Grand Total	

I certify that the family size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before discount is approved.

Name (Print) _____ Signature:_____ Date_____

Verification Check List (attached copies)	**Yes**	**No**
Income: Pay stubs, Tax return, other	☐	☐
Insurance card (optional)	☐	☐

Office Use Only
Completed by_____ Approved by_____ Discount_____ Expires_____